

Ames Laboratory	Procedure:	10200.038
Office: Environment, Safety, Health & Assurance	Revision:	4
Title: Accidents, Incidents & Employee Safety Concerns:	Effective Date:	4/15/2008
Classification & Investigation Procedure		
Page: 1 of 13	Review Date:	4/15/2011

ACCIDENTS, INCIDENTS & EMPLOYEE SAFETY CONCERNS:

CLASSIFICATION & INVESTIGATION PROCEDURE

Comments and questions regarding this policy should be directed to the contact person listed below:

Name: Shawn Nelson
Industrial Safety Specialist
Address: G40 TASF
Phone: 294-9769

Sign-off Record:

Approved by: _____ **Date:** _____
Manager, Environment, Safety, Health & Assurance

Reviewed by: _____ **Date:** _____
Deputy Director

Note: This document's Sign-off Record is maintained in the ESH&A Documents & Records Office, 151 TASF.

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1.0 REVISION/REVIEW LOG

Environment, Safety, Health & Assurance (ESH&A) will review this document once every three years at a minimum:

<u>Revision Number</u>	<u>Effective Date</u>	<u>Contact Person</u>	<u>Pages Affected</u>	<u>Description of Revision</u>
0	9/1/1998	J. Withers	All	Initial Issue
1	11/1/2001	S. Nelson	All	G:\Docs&Recs\DCP\ Revisions Descriptions\102_038rev1
2	3/1/2002	S. Nelson	Page 6	G:\Docs&Recs\DCP\ Revisions Descriptions\102_038rev2
3	4/1/2005	S. Nelson	Numerous	G:\Docs&Recs\DCP\ Revisions Descriptions\102_038rev3
4	4/15/2008	S. Nelson	Numerous	G:\Docs&Recs\102.038 rev 4\Revision Description

2.0 PURPOSE AND SCOPE

The primary purpose of investigating accidents and incidents is to determine what caused the event. By determining the direct, contributing, and root causes, corrective actions can be identified and similar occurrences prevented.

An effective Employee Safety Concerns Program is a key component of an organization's overall environment, safety and health program. Thorough investigation of employee concerns promotes "ownership" of the ES&H program by employees and contributes to the Lab's overall mission of providing a safe and healthy workplace while also protecting the environment.

Results of investigations also provide the basis for compliance with Department of Energy reporting requirements that include the Occurrence Reporting and Processing System (ORPS), Non-Compliance Tracking System (NTS), Incidents of Security Concern (ISC), Worker Safety and Health (WSH) and Computerized Accident & Incident Investigation Reporting System (CAIRS). Occupational Safety & Health Administration (OSHA) reporting requirements are fulfilled via completion of the OSHA 300 and 300A forms.

Information gleaned as a result of investigations is disseminated via the Laboratory's Lessons Learned Program (as appropriate). See Plan 10200.020, Operating Experiences and Lessons Learned Program Plan.

This procedure describes how the Laboratory investigates a work-related injury or incident. The process by which employee safety concerns are investigated is also described.

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3.0 RESPONSIBILITIES

- 3.1 **LABORATORY DIRECTOR** – The Laboratory Director is ultimately responsible for ensuring that investigations of accidents & incidents are conducted in a comprehensive and timely fashion; the Director is also responsible for fostering an environment in which employee safety concerns are shared and addressed.
- 3.2 **PROGRAM DIRECTOR / DEPARTMENT MANAGER** – Program Directors and Department Managers shall work closely with ESH&A and DOE personnel on accident investigations as required; Program Directors and Department Managers shall also ensure that program personnel are encouraged to share concerns and that those concerns will be resolved in a timely manner by working with appropriate Laboratory personnel.
- 3.3 **GROUP / SECTION LEADER** – Group/ Section Leaders shall ensure that group members report all work-related injuries and illnesses to their immediate supervisor and seek medical assistance from the Occupational Medicine office, if necessary; Group / Section Leaders shall encourage the sharing of concerns by employees and participate with appropriate Laboratory personnel in their resolution.
- 3.4 **ENVIRONMENT, SAFETY, HEALTH & ASSURANCE (ESH&A)** – ESH&A will facilitate the implementation of this procedure by working with appropriate Laboratory personnel; ESH&A will also be responsible for classifying incidents including the Occurrence Reporting and Processing System (ORPS), Non-Compliance Tracking System (NTS), Incidents of Security Concern (ISC), Worker Safety and Health (WSH) and Computerized Accident & Incident Investigation Reporting System (CAIRS). ESH&A will conduct investigations as indicated by this procedure, recommending corrective actions and assuring that all required recordkeeping is completed; ESH&A will also serve as the primary contact for any external investigations conducted by DOE.
- 3.5 **OCCUPATIONAL MEDICINE** – Occupational Medicine shall be responsible for treatment or referral of all work-related injuries and illnesses; Occupational Medicine shall also interact with ESH&A on the investigation and classification of incidents and accidents.
- 3.6 **EMPLOYEES** – Ames Laboratory employees shall facilitate the implementation of this procedure by participating in investigations, sharing concerns pertaining to workplace safety and health and the environment with their supervisor, and complying with all relevant ES&H policies and procedures.

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4.0 ACCIDENT & INCIDENT INVESTIGATION AND CLASSIFICATION PROCEDURES

4.1 DOCUMENTATION

Occupational Medicine and/or ESH&A shall evaluate all reported work-related injuries, illnesses and incidents. The Investigation & Recordkeeping Process Form 10200.128 (Appendix A) shows the process that is followed. The following documentation is filled out when a medical evaluation is done after a work-related accident or incident:

- 1) **Patient Status Report** – Form 10200.129 (Appendix B) – This form is filled out by the Occupational Medicine physician and details the diagnosis and any days away and/or work restrictions. The original is kept in the employee's medical records; copies are sent to the employee, ESH&A, supervisor and Beardshear.
- 2) **Supplementary Record of Occupational Injuries & Illnesses** Form 10201.004 (Appendix C) – This form is completed by the patient and supervisor and returned to Occupational Medicine. Occupational Medicine routes the form to ESH&A for review. ESH&A conducts any necessary investigations, and returns the form to Occupational Medicine after a signature from the ESH&A Manager. ESH&A retains the original and sends a copy to Occupational Medicine. On a regular basis, the Occupational Medicine Coordinator, Plant Protection Officer, Industrial Safety Specialist, Industrial Hygienist and ISU Workers Compensation-Human Resources Specialist to confer on the status of each work-related incident. Upon mutual consent, incidents are classified as OSHA-recordable or non-recordable.
- 3) **Work-Related Injury Report** Form 46600.024 (Appendix D) – This form is filled out by Occupational Medicine and delivered to ESH&A immediately upon completion of treatment of a work-related injury.
- 4) **Incident and Concern Reporting** Form 10200.088 (Appendix E) – This form is initiated by either the employee raising the concern or ESH&A and later completed by the ESH&A lead assigned to track the concern.
- 5) **State of Iowa First Report of Injury or Illness** Form 10200.131 (Appendix F) – This form is filled out and sent to 1350 Beardshear Hall, ISU for further processing.

4.2 INVESTIGATION, CLASSIFICATION & REPORTING

All accident investigations and reporting will be conducted in accordance with Plan 40000.001: Event Reporting Program.

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4.3 EMPLOYEE SAFETY AND SECURITY CONCERNS PROGRAM

ESH&A shall document employee concerns utilizing the Incident and Concern Reporting Form 10200.088 (Appendix E). Employees upon request may also fill out this form. Instructions for filling out the forms are as follows:

Date: Date of occurrence/concern.

Time: Time of concern or when report is filed.

Name: Fill in your name.

Bldg./Room: Fill in building and room where concern is located.

Phone: - Fill in your phone number.

ESH&A Point-of-Contact: Name of ESH&A person who received information or was assigned to follow up on issue.

Nature of Incident/Concern - Briefly describe the nature of the concern including time of discovery, any actions taken upon learning of the concerns and previous reporting.

(Form is forwarded to Industrial Safety Specialist at G40 TASf for processing/classification).

Root Causal Determination: Upon completion of the investigation, a root causal determination will be defined for each concern.

Comments: Additional comments pertinent to the concern will be added.

Area of Concern: The concern will be classified in one of the major topical areas listed.

Number: ____ - ____: Each concern will be given a unique number that will correspond to the year and be assigned a sequential number (e.g., 01-001, 01-002, 01-003, etc.).

Acknowledge date: Number of days from point of notification to ESH&A notification of the affected party.

Address date: Number of days from point of notification to concern being formally addressed by ESH&A or other Laboratory entity.

Each concern will be thoroughly evaluated by an ESH&A Specialist. The form shall serve as the mechanism by which documentation of events shall occur. Any supporting documentation will be attached to the form for future reference.

All new employees receive introductory information describing the Employee Safety Concerns Program in General Employee Training (required). Program information is made available to employees on a periodic basis via lab-wide announcements (e.g., Email, Insider, etc.).

4.4 LESSONS LEARNED PROGRAM

Depending on the nature of the incident or accident, the Ames Laboratory Lessons Learned Program may disseminate information from an investigation. A detailed description of the Lessons Learned Program can be found in Plan 10200.020.

4.5 OCCURRENCE REPORTING

All Occurrence Reporting will be conducted in accordance with Procedure 40000.001: Event Reporting Program

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4.6 NON-COMPLIANCE TRACKING SYSTEM (NTS)

All Non-Compliance Tracking System issues will be conducted in accordance with Plan 40000.001: Event Reporting Program

4.7 INCIDENTS OF SECURITY CONCERN

All Incidents of Security Concerns will be conducted in accordance with Plan 40000.001: Event Reporting Program.

4.8 COMPUTERIZED ACCIDENT & INCIDENT INVESTIGATION REPORTING SYSTEM (CAIRS)

All Injury and Illness Reporting will be conducted in accordance with Procedure 40000.001: Event Reporting Program.

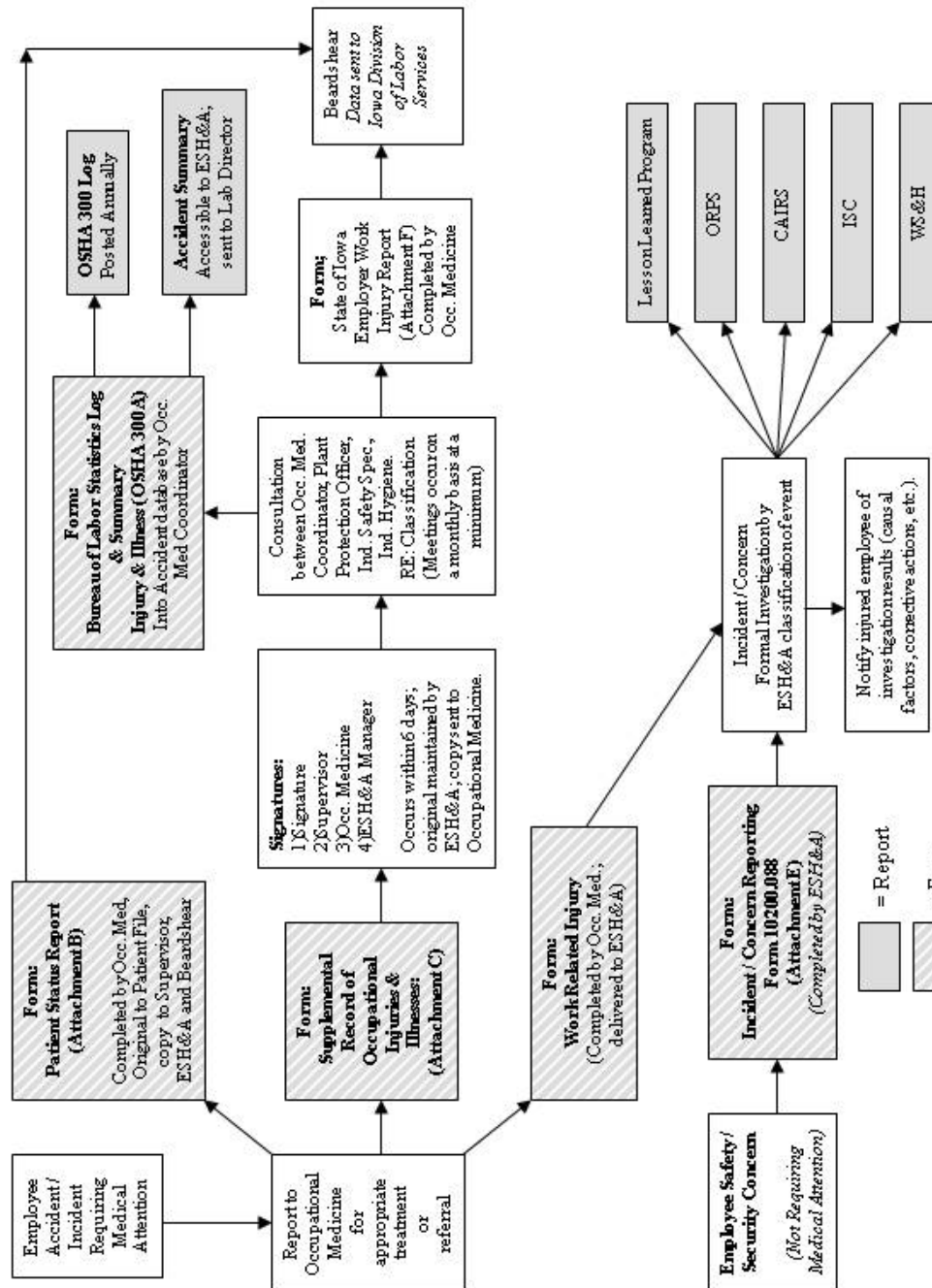
4.9 WORKER SAFETY AND HEALTH NON-COMPLIANCE

All reporting of incidents meeting the threshold of Worker Safety and Health Non-Compliance (10-CFR Part 851) will be conducted in accordance with Procedure 40000.001: Event Report Program.

APPENDICIES

- Appendix A - Diagram 1 - Investigation and Recordkeeping Process (Form 10200.128)
- Appendix B - Form: Patient Status Report (Form #10200.129)
- Appendix C - Form: Supplementary Record of Occupational Injuries & Illnesses (Form 10201.004)
- Appendix D - Form: Work Injury Report (Form 46600.024)
- Appendix E - Form: Incident & Concern Reporting (Form 10200.088)
- Appendix F - Form: State of Iowa Work Injury Report (Form 10200.131)

Appendix A
Diagram 1 Investigation & Recordkeeping Process
Form #10200.128



Appendix B
Form 10200.129 Rev. 1

Iowa State University/Ames Laboratory

Occupational Medicine
Ames, Iowa 50011-3020

515 294-2056
FAX 515 294-1967

PATIENT STATUS REPORT

Time in _____ Time out _____

Patient: _____	Date seen: _____
Diagnosis: _____	Date injured: _____

☐ Unable to perform any work

☐ Fit for full duty on _____

☐ Fit for modified duty* on _____

☐ Anticipated return to work

Full duty _____

Modified duty _____

Work Related: ☐ Yes ☐ No ☐ Undetermined

Work Restrictions:

Comments:

☐ No lifting over _____ lbs.

☐ Avoid repetitive bending and twisting.

☐ No overhead work.

☐ Sit down duties only.

☐ Standing and walking as tolerated.

☐ No use of _____

☐ No repetitive or forceful gripping, pinching, or wrist motions
with hand: ☐ R ☐ L ☐ Both

☐ Keep wound clean and dry.

☐ No overtime work.

☐ Keep splint on _____

☐ No driving or operating dangerous equipment.

☐ No kneeling or squatting.

☐ Limit keyboard use to _____

☐ Avoid exposure to _____

☐ No pushing or pulling.

* If work that satisfies the above limitations cannot be provided,
the patient is not to work and should return as scheduled.

Medication _____

Physical Therapy _____

☐ To return to clinic in _____ days, weeks, months

Date _____ Time _____ am/pm

☐ Referred to _____

☐ Discharged from treatment on _____

Steven R. Sheldahl, M.D.

☐ No permanent impairment anticipated.

**Patient's Signature

** Patient instructions given and patient verbalizes understanding of same. **

Appendix C
Injured/Ill Employee
Form 10201.004

Name _____ **Ames Lab Employee No.** _____
(First, Middle, Last Name)

Home Address _____
Number and Street City State Zip

Age _____ **Gender:** ___ **Male** ___ **Female** **Supervisor #** _____

Job Title _____ **Department** _____

Job Classification (Circle One): P&S, Merit, Graduate, Post Doc, Faculty, Associate or Casual Hourly

Event

Occurred at (Room/Building, Address) _____

What was the employee doing? _____

How did the event occur? (Describe completely) _____

Describe the injury or illness in detail (e.g. "laceration of left index finger requiring stitches", "respiratory irritation", "dermatitis on back of left hand")

What caused the injury/illness: (e.g. "sharp metal edge of shelf", "inhaled vapor from acid", "skin contact with chemical solution")

Date/Time of Event or Diagnosis of injury/illness _____

Name of Treating Physician/Health Care Provider _____

Physician's/Health Care Provider's Address _____
Number/Street City State ZIP

If hospitalized, name/address of hospital _____

Name of Admitting Physician _____

(Continued on other side)

Corrective Actions (Steps taken to prevent recurrence, correct the conditions) _____

What Corrective Action steps remain to be done? _____

Work Restrictions prescribed by Physician/Health Care Provider _____

Lost Work Days
(Days away from work after the day of the event, including week-ends and holidays) _____

Restricted Work Days
(Days in which adjustments needed to be made in tasks or assignments) _____

Prescribed Work Restrictions had an impact on my ability to work YES / NO
(Circle one)

If YES, please comment: _____

Employee Signature_____ **Date**_____

Prescribed Work Restrictions had an impact on the assigned work for the employee YES / NO.
(Circle one)

If YES, please comment: _____

Supervisor's Signature_____ **Date**_____

Return completed form to Occupational Medicine within six days of the event.

Record of Review

Meeting with Executive Council member(s):____ Yes ____No **Comments**_____

Signature of Reviewing Official_____ **Date**_____
Manager, Environment, Safety, Health and Assurance

Appendix D
Form 46600.024

To: ESH&A
G40 Staff

From: Occupational Medicine
G11 TASF

Subject: Work Related Injury Report

Employee's Name: _____

Location of Incident: _____

Injury: _____

Date and time of incident: _____

Occupational Medicine Signature

Date

Appendix E
Form 10200.088

INCIDENT & CONCERN REPORTING FORM

Date: _____ **Time:** _____

☐ Per employee notification to ESH&A (Attach any documentation).

☐ Per Occupational Medicine Report (Attach documentation).

Name: _____ **Bldg./Room:** _____ **Phone:** _____

ESH&A Point-of-Contact: _____

Nature of Incident / Concern *(Include a discussion of investigation and resolution of event):*

(Forward to Industrial Safety Specialist at G40 TASF)

Root Causal Determination (as necessary):

Comments:

Area of Concern:	<input type="checkbox"/> Electrical Safety	<input type="checkbox"/> Fire Safety	<input type="checkbox"/> Egress Path	<input type="checkbox"/> Industrial Hygiene
	<input type="checkbox"/> Health Physics	<input type="checkbox"/> Cylinders/gas	<input type="checkbox"/> Industrial Safety	<input type="checkbox"/> Waste Management
	<input type="checkbox"/> Emissions & P2	<input type="checkbox"/> Hoisting/rigging	<input type="checkbox"/> Property Management	<input type="checkbox"/> Housekeeping
	<input type="checkbox"/> General Safety	<input type="checkbox"/> Other: _____		

Number: _____ - _____ (e.g., 01- 001, 01-002, 01-003, etc.)

Acknowledge date: _____ (# days _____) **Address Date:** _____ (# days _____)

(Copy to ESH&A Manager, Enter into CA5 Database and File in Employee Concerns Folder)

Appendix F
Form 10200.133

Appendix F was intentionally removed from this document in order to generate a PDF of this document. You may review a hard-copy of Appendix F in the ESH&A's Documents & Records Office, 151 TASF.